Revised 08/2018

VALLEY STREAM

UNION FREE SCHOOL DISTRICT THIRTEEN

HEALTH RECORD

(This form must be filled out in its entirety)

SCHOOL: James A. Dever _____ Howell Road _____ Wheeler Avenue _____ Willow Road _____

HISTORY: Date: _____

Pupil Name: _____ DOB: ____/____/____ Grade: _____

Address: _____ Home Phone Number: _____

_____ Cell Phone Number: _____

Mother's Name: _____ Father's Name: _____

Family Doctor: _____

Doctor's Address: _____ Doctor's Phone Number: _____

****

Has your child had any of the following diseases?

	Date		Date
Asthma/ Allergies	_____	Mumps	_____
Diabetes	_____	Pneumonia	_____
Chicken Pox	_____	Rheumatic Fever	_____
Ear Condition	_____	Scarlet Fever	_____
Frequent Colds/ Sore Throat	_____	Seizure Disorder	_____
German Measles	_____	Tuberculosis	_____
Heart Disease	_____	Vision Problems	_____
Measles	_____	Whooping Cough	_____

Operations: _____ Types of Operations: _____ Date: _____

Serious Injuries: _____ Types of Injuries: _____ Date: _____

Was there an unusual pregnancy and/or delivery with this child? Explain _____

_____

Are there any medications your child is currently taking at home?

Medication: _____ Dose: _____ Time(s) Given: _____

Medication: _____ Dose: _____ Time(s) Given: _____

Medication: _____ Dose: _____ Time(s) Given: _____

Is there any other information that you feel will help us to understand and care for your child?

_____

_____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached		☐ Anaphylaxis Care Plan Attached	
☐ Yes, indicate type	☐ Food	☐ Insects	☐ Latex	☐ Medication ☐ Environmental

Asthma ☐ No	☐ Medication/Treatment Order Attached		☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent	☐ Persistent	☐ Other : _____

Seizures ☐ No	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: _____	Date of last seizure: _____

Diabetes ☐ No	☐ Medication/Treatment Order Attached		☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1	☐ Type 2	☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

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UNION FREE SCHOOL DISTRICT THIRTEEN

CERTIFICATE OF IMMUNIZATION

Child's Name: _____ Date of Birth: _____

All incoming students must have a physical exam performed no more than twelve months prior to the start of the school year.

1.) DPT Vaccine 1. __/__/__ 2. __/__/__ 3. __/__/__
4. __/__/__ 5. __/__/__ 6.__/__/__

OR DTaP Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

OR DTaP Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

2.) Tdap Vaccine (For Sixth (6) Grade Entrance) (Effective Sept 2007) 1. __/__/__

3.) Polio (OPV) 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

OR IPV or e-IPV 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__ 5. __/__/__

4.) MMR Vaccine 1.__/__/__ 2. __/__/__

OR Measles 1.__/__/__ 2. __/__/__ Mumps 1.__/__/__ Rubella 1.__/__/__

5.) Hepatitis B 1.__/__/__ 2. __/__/__ 3. __/__/__

6.) Varicella Vaccine 1.__/__/__ 2. __/__/__

OR Disease __/__/__

OR Antibody Titler Level __/__/__ Results: _____

7.) HIB Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__

8.) Lead Test __/__/__ Results: _____

9.) Mantoux Test __/__/__ Results: _____

OR Tine Test __/__/__ Results: _____

10.) Hepatitis A 1.__/__/__ 2. __/__/__

11.) Prevnar Vaccine 1.__/__/__ 2. __/__/__ 3. __/__/__ 4. __/__/__

Prescriber's name and title (please print): _____

Signature: _____ Date: _____

Address: _____ Phone Number: _____

Prescriber's Stamp:

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.